



APPLICATION FOR CERTIFICATION TO PRACTICE HYPNOTISM

State Form 48168 (R3 / 12-02)

Approved by State Board of Accounts, 2002

*** Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

Health Professions Bureau

402 W. Washington St., Room 041

Indianapolis, IN 46204

Telephone number: (317) 234-2051

Email address: hpb6@hpb.state.in.us

Application fee
Date fee paid (month, day, year)
Receipt number
Application number
Certificate number
Certificate issuance date (month, day, year)

APPLICANT
Attach two (2) passport type quality
photographs of yourself taken within the
last eight weeks.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (last, first, middle, maiden)		Social Security number *
Address (number and street or Rural Route)		
City, state, ZIP code		Email address
Telephone number (daytime)	Birthdate (mo., day, yr.)	Birthplace

HIGH SCHOOL OR GED EQUIVALENT EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED

HYPNOTIST EDUCATION

NAME OF STATE APPROVED SCHOOL	LOCATION	DATES ATTENDED

OTHER EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA

NAME OF SCHOOL	LOCATION	FROM (month, year)	TO (month, year)	DEGREE

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM HYPNOTISM SCHOOL	
GENERAL LOCATION	DATE

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM HYPNOTISM SCHOOL		
NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION				
STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details, include the violation, location, date and disposition. If malpractice or civil, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a certification issued pursuant to this application.

- | | |
|---|--|
| 1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you ever been denied a license, certificate, registration or permit to practice Hypnotism or any regulated health occupation in any state (<i>including Indiana</i>) or country? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Are you now being, or have you ever been, treated for a drug abuse or alcohol problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you ever been charged with drug addiction? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have you ever been convicted of, plead guilty or <i>nolo contendere</i> to:
A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?
B. Any offense, misdemeanor or felony in any state? (<i>Except for minor violations of traffic laws resulting in fines.</i>) | <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation other type of discipline or limitations? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign, or retire from any hospital, health care facility or professional association in which you have been associated, trained, held staff membership or privileges, been a member or acted as a consultant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Have you ever had a malpractice judgement or civil action settled against you? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant

Date signed (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request, and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for hypnotist certification.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, person, institutions any information which is material to my application, and I hereby specifically release the Bureau and Board from any and all liability in connection with such disclosure.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to the same.

Signature of applicant

Date signed (*month, day, year*)